SPOTLIGHT ON MARYLAND

MHCC MARYLAND HEALTH CARE COMMISSION

Health Insurance Premiums, the Underwriting Cycle, and Carrier Surpluses

Average health insurance premiums in Maryland for large and small insured groups have risen in double digits for the last several years. The growth in premiums has reflected the growth of health care costs in general, and the cost of medical benefits paid by private insurers, in particular. However, the growth in medical expenses has slowed in recent years, while insured group premiums in Maryland have increased at nearly the same double-digit rate.

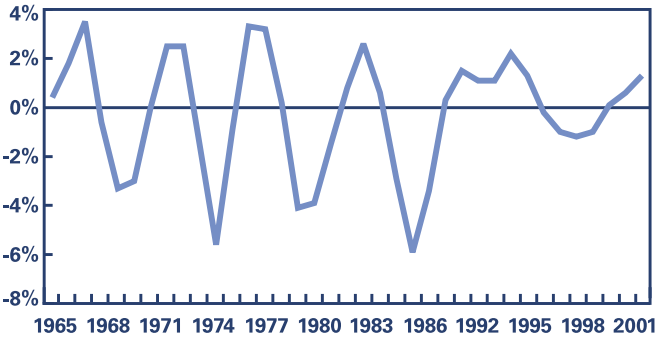
In its most recent expenditure report, the Maryland Health Care Commission reported that medical expenses incurred by third-party payers increased 6 percent, but insurers' premium revenues increased 8 percent overall and nearly 10 percent per capita.[1] The faster growth of total premiums reflects a steep increase in insurers' administrative expenses plus the net cost of insurance—more than 17 percent in 2003, which in Maryland, as in many other States, reflects rising levels of insurer surplus.

Insurers accumulate surplus from annual underwriting gains—direct premiums that exceed medical and administrative costs. Insurers hold surplus against unexpected changes in health care costs or returns on assets, or to finance expenditures on capital assets (such as information technology) or strategic initiatives (new product launches or acquisitions). Some insurers also finance community benefit initiatives from surplus.[2] This spotlight report examines recent changes in surplus among Maryland insurers and the implications for premium increases over the next several years.

The Underwriting Cycle

Historically, insurers have tended to accumulate surplus over a period of about 3 years, and then lose surplus over the next few years (see trends for Blue Cross Blue Shield (BCBS) in Figure 1). Called an underwriting cycle, insurers' characteristic pattern of underwriting gains and losses is largely explained by competition. In periods of underwriting gains, some insurers may seek to build market share by reducing premiums. Other insurers will follow suit to protect their market share. As premiums fall relative to health care costs, many insurers may experience underwriting losses. Premiums will continue to decline relative to medical benefits until a lead insurer with market power raises premiums to restore at least "break even" revenues. As other insurers follow suit, premiums will rise relative to medical benefits, and insurers will try to take underwriting gains to offset the "bad years." Eventually, the cycle will repeat, as one or more insurers will attempt to gain market share at the top of the cycle. If health care costs are rising during the underwriting cycle, consumers may experience the cycle only as changes in average premium growth.

Figure 1: Blue Cross Blue Shield Underwriting Gains and Losses as a Percent of Total Revenues: National Data, 1965–2001



Source: American Hospital Association, Table 1.15 (www.ahapolicyforum.org/ahapolicyforum/trendwatch/chartbook2003.html, accessed December 10, 2004).

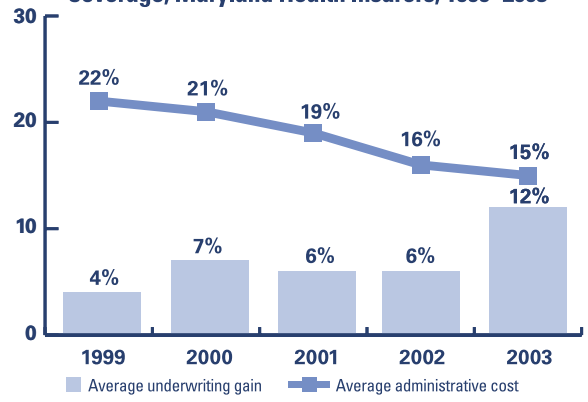
Since 1990, the underwriting cycle has lengthened slightly and the difference between the high and low points of the cycle has diminished. This change may relate to increased concentration in health insurance markets: as fewer and larger insurers dominate the market, smaller insurers may "shadow price" the largest insurers (that is, set prices to mimic the largest insurers) rather than setting the lowest feasible price, which might invite more business than they could manage. Without competitive behavior intended to take market share, an underwriting cycle may not be triggered or may be relatively weak if it does occur. Because regulatory practice in all States in general presumes competition among many insurers, the growing concentration of health insurance markets is a national concern. One recent study identified Maryland among seven States where the five major national carriers controlled approximately 90 percent of the privately insured market.[3]

Nationally, a number of changes in health insurance markets have converged to encourage greater concentration. As health care costs have risen, insurers have focused on reducing administrative costs to constrain the growth of premiums. By acquiring or merging with competitors, they may spread fixed costs over greater premium volume to reduce administrative costs relative to premiums. In addition, for-profit health insurance companies are a growing segment of the market nationally and in Maryland. Capital markets reward for-profit companies for growth, and again, acquiring or merging with competitors is a simple way to achieve rapid growth. The most significant changes in Maryland's health insurance market have been mergers and acquisitions—not net new entry. Most other States have had a similar experience.[4]

Trends in Maryland

Insurers in Maryland have posted underwriting gains averaging 4 to 12 percent each year since 1999 (Figure 2), maintaining surplus of 19 to 27 percent of premium each year, and largely offsetting reductions in administrative costs.[5] While insurers drove average administrative costs for group coverage from 22 percent of premiums in 1999 to 19 percent in 2001 to just more than 15 percent in 2003, consumers have felt little benefit. Instead, insurers have used underwriting gains to build surplus during the upswing of the underwriting cycle, not to reduce premiums.

Figure 2: Average Underwriting Gain and Administrative Cost Trend as a Percent of Premiums for Group Coverage, Maryland Health Insurers, 1999–2003



Source: Mathematica Policy Research tabulation of data from the Maryland Insurance Administration. Annual data are trimmed to omit anomalous reporting. Administrative cost trend is calculated as a moving average.

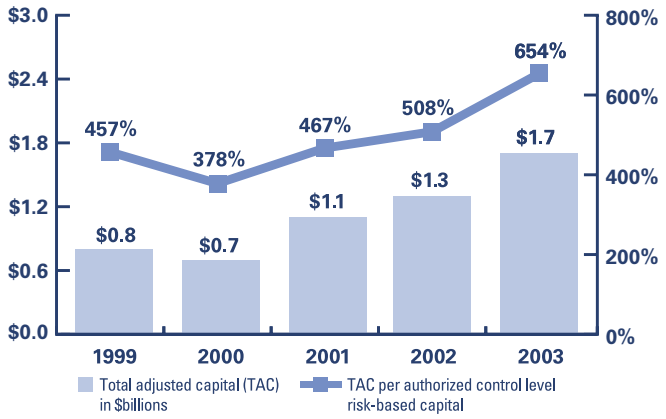
Like insurance regulators in every State, the Maryland Insurance Administration (MIA) requires all insurers in Maryland to hold capital as a buffer against unanticipated medical expenses as well as swings in the value of their invested capital. Surplus generally accounts for all or most of this capital.[6]

The National Association of Insurance Commissioners (NAIC) has established standards by which all insurers measure the capital that they hold using a formula that considers their balance sheet and asset risk, as well as their underwriting, credit, and business risk. This measure defines each insurer's "total adjusted capital" (TAC) as well as its "authorized control level" (ACL) risk-based capital. If an insurer's TAC falls to 200 percent of ACL (called the "company action level"), the insurance regulator may intervene to place the insurer under regulatory control as an early precaution against the insurer becoming insolvent.

While analysts do not agree on the appropriate level for TAC, most would argue that a well-managed carrier should not let TAC drop to 200 percent of ACL. Most insurers in the United States hold surpluses in the range of 350 to 400 percent, even at the low point in the underwriting cycle.

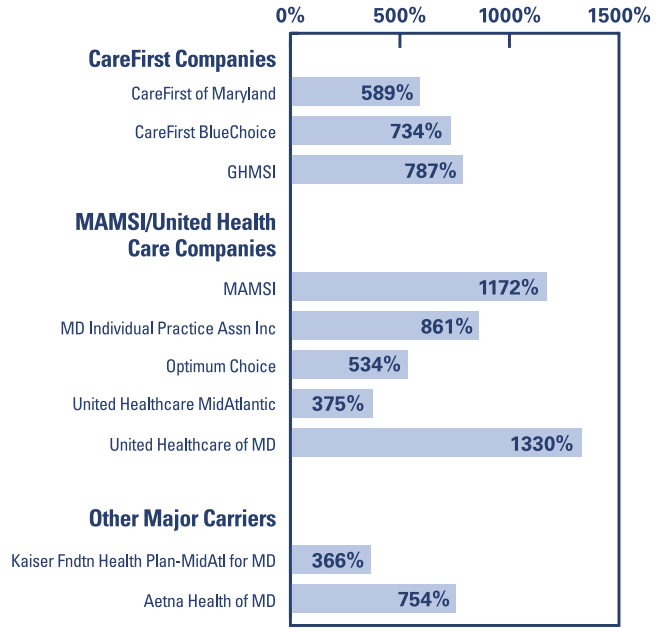
In Maryland, health insurers have more than doubled their surplus or TAC since 1999. Aggregate TAC in Maryland increased from $773 million in 1999, to $1.7 billion in 2003 (Figure 3). In 2003, Maryland insurers' capital assets averaged nearly seven times ACL. In part, this reflects the importance of the CareFirst affiliates in Maryland's market and the higher minimum that the Blue Cross Blue Shield (BCBS) Association sets for its member companies—375 percent of ACL, nearly twice the minimum level of surplus held by other health insurers in the market.[7] Nevertheless, among Maryland companies, the CareFirst affiliates did not hold the highest levels of TAC relative to ACL in 2003 (Figure 4).[8]

Figure 3: Total Adjusted Capital Relative to Regulatory Levels, Maryland Health Insurers, 1999–2003



Source: Mathematica Policy Research analysis of public data from the Maryland Insurance Administration.

Figure 4: Total Adjusted Capital as a Percent of ACL Risk-Based Capital: Selected Major Health Insurers in Maryland, 2003



Source: Mathematica Policy Research analysis of public data from the Maryland Insurance Administration. Figure omits unaffiliated carriers that hold small market shares in Maryland, including Fidelity (which subsequently has merged with UHC), Guardian Life, PHN HMO (subsequently merged with CareFirst), Cigna, Coventry, Unicare (Wellpoint/Anthem), and Connecticut General.

Implications

As the underwriting cycle depresses underwriting gains, Maryland insurers may draw down surpluses over the next several years. Moreover, with growing concentration in Maryland's market, it is possible that the underwriting cycle in Maryland has become longer and shallower as well, and insurers could respond to less market volatility by holding lower surplus throughout the underwriting cycle.[9] If so, and if health care cost growth also slows, Maryland employers could begin to see some benefits from the market concentration that has occurred in the past decade. Both lower administrative costs and reduction of the current, relatively high levels of surplus that most insurers are holding may yield substantially lower premium increases than in recent years.

High surplus offers insurers a competitive advantage: they can use surplus to protect market share against carriers that may try to enter the market. With such high surplus, Maryland carriers are poised to respond aggressively to the threat of market entry, and also to competitors that may try to take market share. As in recent years, new carriers may enter by acquisition, but additional competitors would hesitate to enter a market where the largest carriers are holding such high levels of surplus.

It is hard to say precisely when surpluses become too large. Insurance regulators in general err on the side of caution in encouraging carriers to maintain large surpluses. In a purely competitive market, with many insurers of similar size, a regulatory preference for large surpluses makes sense: the market will require insurers to spend down surplus in the course of normal competition. However, in more concentrated markets, it may have unanticipated negative impacts. A regulatory bias toward large surpluses may increase the consumer cost of insurance without securing greater market stability. Large competing insurers may spend down surplus as they grapple for market share, and large surpluses may provide greater opportunity for such "price wars" to occur. However, it is unlikely that either a large competitor would abandon a well-regulated market or that a new competitor would enter a highly concentrated market.

Some States have worked with large nonprofit insurers, in particular, to direct high surpluses toward broader health care initiatives. For example, Massachusetts has established formal community benefit guidelines for nonprofit HMOs in the State. In December 2004, BCBS of Massachusetts pledged $50 million to the Massachusetts eHealth Collaborative (MaeHC), a nonprofit effort to expand use of electronic health records in Massachusetts.[10] In January 2005, CareFirst announced a $92 million initiative intended to address its community benefit obligations; of this amount, $60 million would be a reduction in premiums against anticipated 2005 levels. In early February 2005, the State of Pennsylvania formalized the prospective "community activities" of the four Pennsylvania Blues plans (though the Commissioner of Insurance ruled that the plans were not operating "with inefficient or excess surplus"). The plans agreed to commit $150 million annually to a 6-year community health reinvestment program, including $85 million to support basic health coverage for low-income and uninsured residents, and $65 million for other community activities related to health care.

[1] Maryland Health Care Commission, *State Health Care Expenditures: Experience from 2003,* Baltimore, Maryland, January 2005.

[2] For example, Kaiser Foundation Health Plan operates "dues subsidy" programs that enroll low-income children and adults for a reduced premium, as well as health education programs for schoolchildren. CareFirst subsidizes Maryland's Senior Prescription Drug Program through its exemption from Maryland's 2 percent tax on indemnity premiums and also administers the program.

[3] J. C. Robinson (November/December 2004). "Consolidation and the Transformation of Competition in Health Insurance," Health Affairs, Volume 23, Number 6, pp. 11-24. This analysis is the most recent of the few that examine competition across States, but it should be considered cautiously. Based on data compiled by Goldman Sachs Global Equity Research, Robinson's estimates exclude Kaiser Foundation Health Plan's significant share of Maryland's market and may exclude other Maryland insurers as well.

[4] D. Chollet et al. (2003). Mapping Health Insurance Markets, 2001: Structure and Change. The Robert Wood Johnson Foundation State Coverage Initiatives Program (*www.statecoverage.net/pdf/mapping2001.pdf*, accessed December 10, 2004).

[5] The codification of statutory accounting procedures in the NAIC's Accounting Practices and Procedures Manual that became effective on January 1, 2001, may be a factor in the change in reported administrative costs between 2000 and 2001. The NAIC initiative, which was adopted by Maryland, consolidated statutory procedures in one manual, but did not preempt State law.

[6] In addition to insurer surplus, insurer TAC may include funds borrowed from a parent company or affiliate (called surplus notes) and statutory reserves.

[7] CareFirst-affiliated companies—CareFirst of Maryland, Blue Choice, and Group Hospitalization and Medical Services (GHMSI)—accounted for an estimated 43 percent of Maryland's combined insured group and individual health insurance market in 2003. By comparison, MAMSI/United Health Care Companies accounted for approximately 27 percent of the combined market, while Kaiser and Aetna accounted for approximately 8 percent and 7 percent, respectively.

[8] Some analysts argue that it may not be appropriate to compare surplus of a Blue Cross organization to the surplus of an entity that is part of a holding company structure; for example, a local insurer operating as a wholly owned subsidiary of a parent company may just hold the statutory minimum surplus levels and get cash infusions from the parent company when necessary; the timing of dividends to the parent company could also affect surplus calculations.

[9] Insurers increasingly raise the issue of holding higher reserves against catastrophic acts of terrorism. There is no way to gauge how high surplus should be for such events. The 109th Congress may consider whether to provide for reinsurance for health insurers in the same way it did for property casualty insurers after the September 11th attacks.

[10] One such effort, the Maryland/D.C. Collaborative for Healthcare Information, seeks to operationalize a secure, HIPAA-compliant, community data exchange (CDE) infrastructure across the State of Maryland and Washington, D.C., region. The Collaborative ultimately will link data from all the components in the Maryland/D.C. health care delivery chain—physician offices, hospitals, clinics, labs, imaging centers, nursing homes, payers, and patients—to securely and appropriately exchange health information. CareFirst indicated support for this initiative in its January 2005 announcement.